FORM APPROVED Division of Licensing and Protection STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 0377 08/13/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 69 1/2 ALLEN STREET **OUR HOUSE TOO RESIDENTIAL CARE HOME** RUTLAND, VT 05701 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 347 R100 Initial Comments: R100 An unannounced onsite complaint investigation was conducted on 08/13/09 by the Division of Licensing and Protection. The following deficiencies were cited. R167 V. RESIDENT CARE AND HOME SERVICES R167 SS=D 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. the Care plan and written behavior plans were Amended to include specific behaviors and Situations that warrant This REQUIREMENT is not met as evidenced R167 8/13 by: Based on record review and interview, the nurse failed to develop a written plan for the use of the PRN (as needed) psychoactive medications for 1 the use of the PRN dose applicable resident. (Resident #1) of Risperdal. 1. Per review on 8/13/09, the care plan for Resident #1 does not describe the specific Frequent monitoring of written plans is expected

Division of Licensing and Protection

D0E911

as behavior patterns and/or

(X6) DATE

behaviors for the use of the psychoactive medication, Risperdal 0.5 mg, prescribed by the physician to be given orally twice daily PRN.

Although the behavior plan dated 8/11/09

Division of Licensing and Protection

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
					C 08/13/2009		
NAME OF PROVIDER OR SUPPLIER STREET ADD 69 1/2 ALI			DRESS, CITY, STATE, ZIP CODE LEN STREET				
4) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETE DATE	
Continued From page 1 describes self abusive behaviors and redirection, it does not specifically address the indication for when the Risperdal showed be administered.			R167	managers and RN.	This 1 of the		
9.1 Environment 9.1.a The home m safe, functional, sa	ust provide and mair nitary, homelike and	ntain a	R266	P.O.C. Accepted Deentosh			
This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide and maintain a safe environment. Findings include:				,		٠	
manager/owner confirmed although aware of Resident #1's exit seeking and ability to remove window screens, creating a safety hazard for the resident, who has cognition and memory impairment, no action was taken to secure the screens. Per review on 8/13/09 of "Comment Sheets" staff describe Resident #1 on 8/6/09 as "wandering quite a bitAt one point she taken the screen out of her window and was standing on her bed trying to climb outthen found (the resident) in the sunroom, trying to climb out of the window which she had taken the screen out of". At 9:25 AM with a staff member, the casement windows (measuring approximately 2.5 ft. wide and 4 ft in length) in Resident #1's room were observed. The screens were noted to be easily removable creating an accessible egress for the			R alele	with an air Condition the arm repaired. So have been reminded importance of report	oner and opervisors of the rting	8/13	
	ROVIDER OR SUPPLIER USE TOO RESIDENT SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa describes self abus it does not specific when the Risperda IX. PHYSICAL PLA 9.1 Environment 9.1.a The home m safe, functional, sa comfortable enviror This REQUIREMEI by: Based on observat review, the facility f safe environment. 1. Per interview on manager/owner co Resident #1's exit s window screens, co resident, who has o impairment, no act screens. Per revie Sheets" staff descr "wandering quite the screen out of h on her bed trying to resident) in the sur the window which s of" At 9:25 AM with a windows (measurir and 4 ft in length) in observed. The scre removable creating	OST CORRECTION 0377 ROVIDER OR SUPPLIER USE TOO RESIDENTIAL CARE HOME SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM.) Continued From page 1 describes self abusive behaviors and reit does not specifically address the indic when the Risperdal showed be adminis IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and mair safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as eviby: Based on observation, interview and rereview, the facility failed to provide and safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM manager/owner confirmed although aw Resident #1's exit seeking and ability to window screens, creating a safety haza resident, who has cognition and memor impairment, no action was taken to see screens. Per review on 8/13/09 of "Cor Sheets" staff describe Resident #1 on 8 "wandering quite a bitAt one point the screen out of her window and was son her bed trying to climb outthen for resident) in the sunroom, trying to climb the window which she had taken the scommodium of the screen out of her window and the screen observed. The screens were noted to be removable creating an accessible egreen.	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide and maintain a safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner confirmed although aware of Resident #1's exit seedent who has cognition and memory impairment, no action was taken to secure the screens. Per review on 8/13/09 of "Comment Sheets" staff describe Resident #1 on 8/6/09 as "wandering quite a bitAt one point she taken the screen out of the windows (measuring approximately 2.5 ft. wide and 4? 12.5 AM with a staff member, the casement windows (measuring approximately 2.5 ft. wide and 4? 15 room were observed. The screens were noted to be easily	ROVIDER OR SUPPLIER USE TOO RESIDENTIAL CARE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG). Continued From page 1 describes self abusive behaviors and redirection, it does not specifically address the indication for when the Risperdal showed be administered. IX. PHYSICAL PLANT 9.1 a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide and maintain a safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner confirmed although aware of Resident #1's exit seeking and ability to remove window screens, creating a safety hazard for the resident, who has cognition and memory impairment, no action was taken to secure the screens. Per review on 8/13/09 of "Comment Sheets" staff describe Resident #1 on 8/6/09 as "wandering quite a bitAt one point she taken the screen out of her window and was standing on her bed trying to climb outthen found (the resident) in the sunroom, trying to climb out of the window which she had taken the screen out of" At 9:25 AM with a staff member, the casement windows (measuring approximately 2.5 ft. wide and 4 ft in length) in Resident #1's room were observed. The screens were noted to be easily removable creating an accessible egress for the	SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY ORLSS IDENTIFYING INFORMATION). SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY ORLSS IDENTIFYING INFORMATION). Continued From page 1 describes self abusive behaviors and redirection, it does not specifically address the indication for when the Risperdal showed be administered. IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner confirmed although aware of review, the facility failed to provide and maintain a safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner confirmed although aware of review, the facility failed to provide and maintain a safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner confirmed although aware of review, the facility failed to provide and maintain a safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner confirmed although aware of review, the facility failed to provide and maintain a safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner confirmed although aware of review, the facility failed to provide and maintain a safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner confirmed although aware of review, the facility failed to provide and maintain a safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner confirmed although aware of review, the facility failed to provide and maintain a safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner confirmed although aware of review, the facility failed to provide and maintain a safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner	SUMMARY STATEMENT OF DEFICIENCIES SOURCE STATE ADDRESS, CITY, STATE ZIP CODE 89 1/2 ALLEN STREET RUTLAND, VT 05701 PREFIX TAG PROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY IN THE APPROPRIATE STATE ADDRESS, CITY, STATE ZIP CODE 89 1/2 ALLEN STREET RUTLAND, VT 05701 PREFIX TAG PROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY I EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTIVE ACTION TO THE APPROPRIATE DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG TO THE APPROPRIATE PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG THE APPROPRIATE TAG TO THE APPROPRIATE PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG THE APPROPRIATE PREFIX TAG THE APPROPRIATE PREFIX TAG THE APPROPRIATE THE APPROPR	

D0E911

Division of Licensing and Protection											
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED						
		0377	L OTDEET AD	DREGG OITY O	TATE TIP CORE	08/1	3/2009				
	ROVIDER OR SUPPLIER USE TOO RESIDENT	IAL CARE HOME	69 1/2 AL	LEN STREE), VT 05701	BTATE, ZIP CODE T						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLETE					
R266	Continued From page 2			R266							
:	exit on 8/6/09 was observed to be broken creating an expandable space suitable for Resident #1 to attempt an exit. Per interview, the manager confirmed although aware of the issues with the screens, staff had not informed her of the broken window in the sunroom. During the onsite, the facility manager was asked to take immediate action to secure the screens and repair the window in the sunroom. Hardware was purchased and the manager/owner began installation and repair immediately. 2. On 8/13/09 at 10:35 AM accompanied by the manager observations of the back yard, into which the deck off of the dinning room exits, revealed 2 large gaps between the back side of the fence and the ground where soil had eroded measuring approximately 12 to 15 inches in height. In addition, where the bottom step of the deck meets the ground a large whole (approximately 8 inches by 10 inches) was observed, creating a hazard for staff, family and residents who utilize the deck and exit from the deck into the back yard.			021.10	The Leck is New and fill		8/15				
				RZULE	The deck is New and has been completed Crushed Stone Now Surrounds the decito ground. Low Spots observed between fence and quere filled immedia and Finished Lands is expected by Sex when the ground wand plants added control the washow that the Land has prone to mild erro	pround ately scaping of 4th work shoold with shoold wi	9/4				
•	•				9/3/09 P.OC Accepted DeDoethorn						

D0E911